



**WALPOLE MEDICAL RESERVE CORPS
BOARD OF HEALTH**

135 School Street
Walpole, MA 02081
Telephone: 508-660-7320 FAX: 508-668-2240

VOLUNTEER APPLICATION

Name

Last: _____ First: _____ MI: _____

Address

Street: _____ City: _____ State: _____ Zip: _____

Phone

Home: _____ Work: _____ Cell: _____

E-mail: _____ Pager: _____

Personal Data

DOB(mm/dd/yy)

Social Security Number

Driver's License Number/State

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

During which hours are you available for volunteer assignments?

____ Weekday mornings

____ Weekday afternoons

____ Weekday evenings

____ Weekend mornings

____ Weekend afternoons

____ Weekend evenings

Paid / Volunteer Experience

Organization

Dates

Position

Supervisor

Address: _____ Telephone: _____

Description of Responsibilities

Questions? Call 508-660-7320 or e-mail rchapell@walpole-ma.gov

Licenses & Certifications:

Medical License (specify type)	State	Number	Expiration
Nursing License (specify type)	State	Number	Expiration
EMT/Paramedic License (specify type)	State	Number	Expiration
Other License (specify type)	State	Number	Expiration
Certification (list/describe)			Expiration
Certification (list/describe)			Expiration

Have you ever had your professional license suspended or revoked? ____ No ____ Yes (Please attach letter of explanation)

Have you ever been convicted of a felony, or of a misdemeanor that resulted in imprisonment, which was not a first offense? ____ No ____ Yes

Do you have a current MA driver’s license? ____ Yes ____ No

Volunteer Interests:

_____ Administration	_____ Clinical, dispense medicines, triage	_____ Behavioral Health
_____ Public Safety	_____ Fundraising	_____ Deliveries
_____ Phone Bank	_____ Newsletter Production	_____ Clerical Help
	_____ Volunteer Coordination	

References: Please list three references who are familiar with your qualifications/experience. Do not list relatives.

Name _____ Phone Number _____

Address _____

Name _____ Phone Number _____

Address _____

Name _____ Phone Number _____

Address _____

Volunteer Consent for Reference & Background Checks:

I do hereby give the Walpole Medical Reserve Corp (WMRC) permission to inquire into my educational background, references, driving record, employment, volunteer history and police record. I further give permission to the holder of such records to release the same to the WMRC. I hereby hold the WMRC harmless of any liability, whether civil or criminal, that may arise as a result of the release of the information about me. I further hold harmless any individual, agency, business or corporation that provides documents to the WMRC. I understand that the WMRC will use this information as part of its verification of my volunteer application. I further understand that as a Medical Reserve Corps volunteer, I am not paid for my services. I further understand I will be required to sign a Code of Conduct upon approval of my application.

Volunteer Consent for Release of Information:

I do hereby give the WMRC permission to release personal information with local, state, and federal emergency management agencies and other Health & Human Service agencies as needed.

Name (please print)

Signature

Today's date